	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE C	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUII	DING	01	COMPLE 01/20/2	
		133440	B. WIN		A PROPERTY OF THE CASE OF THE	01/20/2	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE VILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ΓER		WAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY	+	DATE
ROOOO							
	A Life Safety Co	ode Recertification	K00	00	This Plan of Correction is the center's	ne center's	
	=	sure Survey was			credible allegation of compliance.		
	conducted by the Indiana State			Preparation and/or execution o		olan	
	Department of				of correction does not constitute admission or agreement by the provide	der	
	-	h 42 CFR 483.70(a).			of the truth of the facts alleged or conclusions set forth in the statement	of	
	Survey Date: 0	1/20/12			deficiencies. The plan of correction is prepared and/or executed solely beca it is required by the provisions of fede and state law.	ause	
	Facility Number: 000476 Provider Number: 155446						
	AIM Number:						
	, and realiser.	100230070					
	Surveyor: Amy	Kelley, Life Safety					
	Code Specialist						
	At this Life Safe	ety Code survey,					
	Covington Man	or Health and					
	Rehabilitation (Center was found					
	not in compliar	nce with					
	-	or Participation in					
	Medicare/Medi	caid, 42 CFR					
	Subpart 483.70						
	=	he 2000 edition of					
	the National Fir	re Protection					
	Association (NF	PA) 101, Life Safety					
		410 IAC 16.2. The					
	original buildin	g consisting of the					
	_	t wing, Bed and					
	_	and the service hall					
	was surveyed w	vith Chapter 19,					
	-	Care Occupancies.					
	-						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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03N321

Facility ID: 000476

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446			LDING	NSTRUCTION 01	(X3) DATE COMPL 01/20 /	ETED
		100770	B. WIN		DDDEGG CITY OT TO CORE	01/20/	2012
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEN	ΓER		VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCT)		DATE
	This one stone	facility was					
	This one story						
	determined to be of Type V (111) construction and was fully						
		he facility has a fire					
	alarm system v						
	detection in corridors and areas						
		rridors. The facility					
		of 149 and had a					
	census of 135	at the time of this					
	survey.						
		Robert Booher, Life Safety					
	Code Specialist-Me	dical Surveyor on 01/26/12.					
	The facility was	found not in					
	compliance wit						
	aforementione						
		is evidenced by the					
	following:	is evidenced by the					

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Event ID: 03N321

Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155446	B. WIN			01/20/	2012
NAME OF B	AD CAMPED ON GAMPA IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			5700 W	ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
			 	TAG	DEFICIENCY)	1	DATE
K0029 SS=E	One hour fire rated fire-rated doors) or fire extinguishing s 8.4.1 and/or 19.3.8 areas. When the a extinguishing systemates are separated smoke resisting pareself-closing an protective plates the inches from the borgermitted. 19.3. Based on observinterview, the frequency that the soiled linen, the hazardous area a door that would latch into the frequency fire sidents in the unit. Findings include Based on observinterview in the frequency fire frequency fire sidents in the unit.	rvation and facility failed to ridor door to 1 of 1 in the Bed and used for storage of erefore creating a a, was provided with uld self close and rame. This ce could affect 23 e Bed and Breakfast le: rvation with the irector on 2:45 p.m., two rrels were stored in	K00	TAG	1. The identified door had a sclosing device installed. 2. All soiled linen storage roowere reviewed for self closing devices 3. Maintenance director will review these doors monthly to ensure they are in working ord 4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter	self oms er. De	DATE 02/12/2012
	door lacked a s	elf closing device.					
		terview with the					
		irector at the time					
	maintenance Di	in cettor at the time	1				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155446	(X2) MULTIPLE A. BUILDING B. WING	01	COM	TE SURVEY TPLETED 20/2012
COVING	ROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	5700	ET ADDRESS, CITY, STATE, ZIP) WILKIE DR T WAYNE, IN 46804	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	of observation, soiled linens are stored in these barrels until they are taken by the laundry staff to the laundry room. 3.1–19(b)	TAG	DEFICIENCY)		DATE

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Event ID: 03N321

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ		ONSTRUCTION 01	(X3) DATE S COMPL	
		155446	A. BUI B. WIN	LDING		01/20/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				VILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		WAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG K0064		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
SS=E		guishers are provided in all ancies in accordance with					
00-L		6, NFPA 10					
	Based on obser	vation and	K00	064	The identified placard was		02/12/2012
	interview, the f	acility failed to			purchased and installed 2. There are no further		
	maintain 1 of 1	K Class portable			extinguishers that meet this		
	fire extinguishe	ers in the kitchen			requirement		
	cooking area in	accordance with			3. Dietary staff will be in		
	the requiremen	its of NFPA 10,			serviced on utilizing the fire protection system on the hood	, l	
	Standard for Po	ortable Fire			should be used prior to the		
	Extinguishers,	1998 Edition. NFPA			extinguisher. The Maintenance		
	10, 2– 3.2 requ	iires fire			Director will review the continuplacement of the identified sign	-	
exting	extinguishers p	provided for the			quarterly with his routine fire drills.		
	protection of co	ooking appliances			4. Results of audits will		
	use combustibl	e cooking media			forwarded to QA&A		
	(vegetable or a	nimal oils and fats)			committee for tracking ar	nd	
	shall be listed a	and labeled for			trending monthly for 3		
	Class K fires. N	NFPA 10, 2-3.2.1			months then quarterly		
	requires a placa	ard shall be			thereafter		
	conspicuously	placed near the					
	extinguisher w	hich states the fire					
	protection syst	em shall be					
	activated prior	to using the fire					
	extinguisher. S	Since the fixed fire					
	extinguishing s	system will					
	automatically s	hut off the fuel					
	source to the c	ooking appliance,					
	the fixed syster	m should be					
	activated befor	e using a portable					
	fire extinguishe	er. In this instance,					
	the portable fir	e extinguisher is					
	supplemental p	protection. This					
	deficient practi	ce could affect any					
	residents using	the main dining	\perp				

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Event ID: 03N321

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155446	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 01	COM	TE SURVEY MPLETED 20/2012
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	570	EET ADDRESS, CITY, STATE, ZI 0 WILKIE DR RT WAYNE, IN 46804	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	room and all kitchen staff.				
	Findings include:				
	Based on observation with the Maintenance Director on 01/20/12 at 1:35 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Director at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system. 3.1–19(b)				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	A. BUI	LDING	ONSTRUCTION 01	(X3) DATE COMPI 01/20	LETED
		130440	B. WIN			01/20	12012
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	ITER	5700 W	ADDRESS, CITY, STATE, ZIP CODE /ILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
	Electrical wiring ar accordance with N Electrical Code. 9. Based on obser interview, the fensure 1 of 1 w care areas in the Breakfast unit is room and 1 of rooms were profault circuit into protection again NFPA 70, Article Facilities, defining patient care area wet conditions present. These fluids on the flui	and equipment is in IFPA 70, National 1.2 Evation and facility failed to vet location resident in Bed and such as the shower 3 staff medication ovided with ground errupter (GFCI) inst electric shock. The seas subjected to while patients are expected include standing for or drenching of either of which imate to the patient 70, 517–20 Wet hires all receptacles of the location to have in the Moisture can tact resistance of electrical insulation in the failure. This is ce affects any of its in the Bed and and any staff using East wing nurses' tion room in the	KO	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP	gs ited plugs tor y of II be	
i	event of an elec	ctrical short.					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		ULTIPLE CO LDING	NSTRUCTION 01	COM	TE SURVEY PLETED 20/2012
		155446	B. WIN	_			:0/2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COI ILKIE DR	DE	
COVING ⁻	TON MANOR HEAL	TH AND REHABILITATION CE	NTER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVEDENCE N		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings includ	le:					
	a. Based on ob	servation with the					
	Maintenance Director on						
	01/20/12 at 12:42 p.m., the Bed						
		hower room had an					
	electrical recep	tacle on the wall					
	within three feet of a sink which						
	was not provided with GFCI						
	protection to prevent electric						
	shock. Based o	on an interview with					
	the Maintenand	e Director at the					
	time of observa	ation, he confirmed					
	the circuit brea	ker for this outlet					
	was also not pr	ovided with GFCI					
	protection to p	revent electric					
	shock.						
	b. Based on an	observation with					
	the Maintenand	e Director on					
	01/20/12 at 12	2:30 p.m., the East					
	wing nurses' st	ation medication					
	room had an el	ectrical receptacle					
	on the wall witl	hin three feet of the					
	hand sink whic	h was not provided					
	with GFCI prot	ection to prevent					
	electric shock.	Based on interview					
		enance Director at					
	the time of obs	*					
		receptacle was not					
	on a GFCI brea	ker.					
	3.1-19(b)						

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155446	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 01/20/2012			
COVING	ROVIDER OR SUPPLIER FON MANOR HEALTH AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	02	COMPL	LETED
		155446	B. WIN			01/20	/2012
		<u> </u>	D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			VILKIE DR		
COVING	TON MANOR HEAL	LTH AND REHABILITATION CEI	ITER		WAYNE, IN 46804		
			1121		W/(TIVE, IIV 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
K0000							
	Ī				This Plan of Correction is the center	'n	
	A Life Safety Co	ode Recertification	K0	000	credible allegation of compliance.	S	
	and State Licensure Survey was				, , , , , , , , , , , , , , , , , , , ,		
	conducted by t	the Indiana State			Preparation and/or execution of this	plan	
	Department of				of correction does not constitute admission or agreement by the provi	der	
	I	th 42 CFR 483.70(a).			of the truth of the facts alleged or		
	accordance wit	11 42 CIR 403.70(a).			conclusions set forth in the statement deficiencies. The plan of correction is		
					prepared and/or executed solely bed		
	Survey Date: 01/20/12				it is required by the provisions of fed	eral	
					and state law.		
	Facility Number: 000476						
	Provider Number: 155446 AIM Number: 100290870						
		00_000.0					
	Curiovori Ami	. Kallay Lifa Cafaty					
	· · · · · · · · · · · · · · · · · · ·	Kelley, Life Safety					
	Code Specialist	t					
	At this Life Safe	ety Code survey,					
	Covington Man	or Health and					
	Rehabilitation (Center was found					
	not in complia						
	· ·	for Participation in					
	· -	•					
	Medicare/Medi						
	•	O(a), Life Safety					
	from Fire and t	the 2000 edition of					
	the National Fi	re Protection					
	Association (NI	FPA) 101, Life Safety					
		1 410 IAC 16.2. The					
	new section of						
		he Rehabilitation					
	1						
	wing was surveyed with Chapter						
	18, New Health	n Care Occupancies.					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	02	COMPLETED
		155446	B. WI	NG		01/20/2012
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	
					ILKIE DR	
COVING	TON MANOR HEA	LTH AND REHABILITATION CE	NIER	FORTV	VAYNE, IN 46804	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCT)	DATE
	This one story					
		be of Type V (111)				
	construction a	-				
		he facility has a fire				
	alarm system					
		orridors and areas				
		orridors. The facility				
		of 149 and had a				
		at the time of this				
	survey.					
		s found not in				
	compliance wi					
	aforementione	- ·				
		as evidenced by the				
	following:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446			ULTIPLE CO LDING	02	(X3) DATE COMPL 01/20	ETED	
		155446	B. WIN			01/20/	2012
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	ITER	5700 W	ADDRESS, CITY, STATE, ZIP CODE VILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0051 SS=E	installed according effective warning of building. Activation alarm system is by initiation, automative extinguishing system are located in the or written records reliable second so Fire alarm system accordance with Nalarm Code, and recordance with Sept readily availa annunciation of the approved central sept seed on observinterview, the fensure 1 of 1 sept the Rehabilitation room was not inflow would advoperation. NFF requires in spathandling system to be located prevents operations. This	ces or equipment is go to NFPA 72, to provide of fire in any part of the en of the complete fire y manual fire alarm ic detection, or em operation. Pull stations path of egress. Electronic of tests are available. A surce of power is provided. If the end of the end	K00	051	1. The identified smoke determas relocated the required distance from the vent 2. All electrical rooms were reviewe for any smoke detectors that located too close to vents and were addressed as needed. The maintenance director will continue to monitor any installation of future smoke detectors to ensure they are vin state guidelines 4. Results audits will be forwarded to QA committee for tracking and trending monthly for 3 months then quarterly thereafter	ed are d 3. with of A&A	02/12/2012

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		ILDING	NSTRUCTION 02	COM	TE SURVEY IPLETED 20/2012
	PROVIDER OR SUPPLIE	R LTH AND REHABILITATION CE	NTER	5700 W	ADDRESS, CITY, STATE, ZIP C ILKIE DR VAYNE, IN 46804	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	had a smoke o within three fe duct. This was	wing electrical room letector located et of an supply air s acknowledged by ce Director at the					

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